

# Health Equity

## Introduction:

Over the last century Maine has made progress in protecting and improving health and reducing the differences in health outcomes between groups defined by their social, demographic, environmental, and geographic characteristics. However, some health inequalities persist between the general public and certain groups or populations.

## Maine Summary Health Measures

Different populations in Maine have specific health disparities, some of which are highlighted in the other chapters of Healthy Maine 2020. In addition, there are disparities in general health measures, including life expectancy, general health status, and years of potential life lost.

A core Maine value is *fairness*. Health equity in Maine means all people deserve a fair opportunity to make the choices that allow them to lead longer, healthier, and more productive lives. We have known that the risk for death, illness and injury, unhealthy behaviors, and reduced access to high quality care increases when income and education are lower. However, data now shows additional elements of social disadvantage (such as income inequality between groups) are also factors (determinants) which impact population health, and can have an additive impact over the lifespan. Intervention research shows many of these persistent health disparities are **not inevitable** – many can be changed or prevented.<sup>1</sup>

Known health inequities are linked to factors such as race/ethnicity, income, lifetime education, gender, disability, sexual orientation, age, and geographic location. People at some stages of the lifespan have extra vulnerability due to dependence on others for one's welfare and health. We also recognize increased vulnerability in other specific

Maine populations as well, such as those with low proficiency in English, cultural challenges experienced by newly arrived refugees, or trauma experienced by our veterans. To protect and improve population health for all requires working towards health equity. Eliminating health disparities requires a multi-sector, multi-level approach that includes all segments of a community and taking specific action for certain groups on the determinants of health.

## Life Expectancy

Maine's life expectancy rates are a stark illustration of health disparities. By this measure, Maine ranks as one of the healthier states in the nation.

Average life expectancy rates in Maine's 16 counties vary by as much as 3.2 years (78.8 yrs. -75.6 yrs. in 2009).<sup>2</sup>

Life expectancy rates are more than 20 years lower for members of the four Tribal nations in Maine compared to Maine residents.<sup>3</sup>

Over the last decade, the life expectancy for women in Washington County decreased. This is the only county in New England to see such a decrease.<sup>4</sup>

In other words, where any group of people lives in Maine is one factor linked to more vulnerability to their premature death.

Each of the chapters in Healthy Maine 2020 highlights a population for which evidence shows a higher rate of preventable disease, injury or other health-related condition related to the key area. The highlights do not include all populations disproportionately affected in that area, but serve to point out an example where targeted actions with a specific population are necessary to effectively address a health disparity. Systems and communities shape our health, as do our

own behaviors, so healthy lives are dependent on multiple factors at every level. This chapter serves as a primer for the issues related to health equity and health disparities.

### Data Limitations related to Disparities Populations:

Maine, like many other states, does not collect sufficient data to consistently or systematically monitor and address health disparities in all populations. Survey samples and populations of some demographic subgroups can be too small to yield valid and reliable data. Lack of consistency across survey systems (i.e. using the same definitions and data collection methods) may prohibit combining datasets to achieve larger samples or track trends. In a rural state, small population numbers make it challenging to develop statistically reliable and anonymous data for some health problems. Where we have state or sub-state quality data to reference in this document, we do note disparities that are visible in the data. When data is lacking, Maine in practice relies on the national level evidence for data on specific populations to infer potential impacts on health for specific populations. While the data on health disparities is limited in this Healthy Maine 2020 Brief, more complete information is provided in the 2012 State Health Assessment.

### Populations with Persistent Health Disparities

Maine has a total population of 1,328,361 people.<sup>5</sup> This population includes subset groups who experience persistent health disparities. According to the 2012 National Plan of Action to End Health Disparities a health disparity is defined as “a particular type of health difference that is closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health and/or a clean environment based on their racial or ethnic group;

religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation; geographic location; or other characteristics historically linked to discrimination or exclusion.<sup>6</sup>

Health disparities are linked to the social determinants of health. This term includes the resources and social conditions in which people are born, live, learn, work, play, worship, and age which affect a wide range of health, functioning, and quality-of-life outcomes and risks. It is important to note that this section highlights many populations with persistent health disparities, but is not a comprehensive list.

### Race and Ethnicity

Race and Ethnicity classifications were last defined by the Office of Management and Budget (OMB) in 1997, which includes five race categories (Black or African American, White, Asian, American Indian or Alaska Native, and Native Hawaiian or Other Pacific Islander) as well as one ethnic population (Hispanic/Latino or non-Hispanic/Latino).<sup>7</sup> In addition, the Census and many health surveys allow for the self-designation of multiple races by an individual, which is often presented as a “two or more races” or “multiple races” category.

Change in Population, by Race/Ethnicity

	2000	2010	% Change
White	1,236,014	1,264,971	2.3%
Black/African American	6,760	15,707	57.0%
American Indian /Alaska Native	7,098	8,568	17.2%
Asian	9,111	13,571	32.9%
Native Hawaiian /Pacific Islander	382	342	-11.7%
Some other Race	2,911	4,261	31.7%
Two or More Races	12,647	20,941	39.6%
Hispanic	9,360	16,935	44.7%
Non-Hispanic	1,265,563	1,311,426	3.5%
Total Population	1,274,923	1,328,361	4.0%

factfinder2.census.gov US Census 2010

For several years, numerous research studies have demonstrated that members of a racial or ethnic minority group experience more health disparities and receive lower quality health care than majority groups. In general, white non-Hispanic people have better health outcomes as a racial/ethnic category.<sup>8</sup>

In Maine, the number of racial and ethnic minorities has increased since the 2000 Census. In a comparison from the 2000 to 2010 Census, Maine’s total population grew slowly at 4%, while the percentage of change for most race/ethnicity categories other than white or non-Hispanic has seen marked growth, ranging from 17.2% to 57.0%.<sup>9</sup> Further, as the next section will detail, those who belong to a race or ethnic group other than white, non-Hispanic are much more likely to live in poverty. Nearly half of the Black/African Americans and over a third of all American Indian/Alaska Native in Maine are in poverty.<sup>10</sup>

**Maine and US Population and Poverty by Race/Ethnicity**

	Population		Poverty	
	US	Maine	US	Maine
White	72.4%	95.2%	13.0%	11.8%
Black/African American	12.6%	1.2%	28.1%	42.6%
American Indian /Alaska Native	0.9%	0.6%	29.5%	35.9%
Asian	4.8%	1.0%	12.8%	16.7%
Native Hawaiian /Pacific Islander	0.2%	--	21.5%	24.7%
Some other Race	6.2%	0.3%	28.5%	32.8%
Two or More Races	2.9%	1.6%	21.4%	24.3%
Hispanic	16.3%	1.3%	25.8%	11.8%
Non-Hispanic	83.7%	98.7%	11.0%	25.5%

[2010.census.gov/2010census/data](http://2010.census.gov/2010census/data); [factfinder2.census.gov](http://factfinder2.census.gov)

While small numbers have limited our knowledge of disparities for various racial and ethnic populations in Maine, we know that disparities exist at a national level and these are likely to be affecting Maine’s racial and ethnic minorities. Given cultural differences in many of these populations, whether

they are new residents or have lived in Maine for generations, culturally appropriate services need to be developed. This highlights the need for both general and focused education and interventions in our public health efforts.

### Socioeconomic Status

The US Center for Disease Control and Prevention defines socioeconomic status as a composite measure that typically incorporates economic (income), social (education), and work status (employment). Each of these is considered an indicator, and they are related but not the same. Income, education, wealth and neighborhood income have significant effects on health, ability to choose healthy lifestyles and access to health services.

**Socioeconomic Comparison (2008-2009)**

	US	Maine
<b>Income</b>		
People in Poverty	15.9%	14.1%
<b>Education Status of those in Poverty</b>		
Less than High School	15.9%	25.1%
High School Graduate	27.9%	11.9%
Some College/Associate Degree	14.2%	8.4%
Bachelor’s Degree or Higher	10.5%	3.7%
Graduation Rate	75.5%	83.8%
<b>Employment</b>		
Unemployment Rate	10.3%	8.6%

[factfinder2.census.gov](http://factfinder2.census.gov) 2008-2009; [nces.ed.gov/programs/coe/indicator\\_scr.asp#info](http://nces.ed.gov/programs/coe/indicator_scr.asp#info)

Poverty is one of the most significant factors in determining health outcome.<sup>11</sup> Poverty is associated with adverse social and physical development, particularly in early childhood. Those in poverty suffer higher rates of psychological disorders, poor academic and social functioning, and increased prevalence of chronic disease outcomes.

Education is one of the strongest predictors of health: the more schooling people have the better their health is likely to be. Research evidence

suggests that education exerts the strongest influence on health likely because of its strong relationship to both income and occupation. A higher proportion of those who do not complete high school live in poverty as compared to those in another educational group.<sup>12</sup> Those with more education have more opportunities for better paying jobs, housing in safer neighborhoods, access to nutritious foods and better medical care and health insurance. In 2012, Healthy People 2020 adopted a measurable objective to increase rates of high school graduation as an intervention to improve health status.

### Lesbian Gay Bisexual Transgender (LGBT)

The acronym LGBT is often used as an umbrella term as if there was one single community. In fact it refers to several distinct groups, each with its own subgroups defined by their race and ethnicity, socioeconomic status, age, geographic location and/or other factors. The 2011 Institute of Medicine study of the health needs of lesbian, gay, bisexual and transgender people described this population as consisting of two overlapping categories: sexual orientation and gender identity. “Sexual orientation” refers to some combination of sexual attraction, behavior or identity, with the shared fact of not being exclusively heterosexual, and includes lesbians, gay men, bisexual men and women along with those people who do not use such a label but who nevertheless experience same-sex attraction or engage in same-sex sexual behavior. “Gender identity” refers to a person’s identification and presentation to a gender, which may be different than the sex assigned to them at birth. People with gender identities that are not the same as their biological sex at birth are often referred to as “transgendered” a term that includes those people who vary from or reject traditional cultural norms of gender.<sup>13</sup>

**Sexual Orientation, by County**

	Heterosexual	Homosexual	Bisexual	Other
Androscoggin	97.2%	1.5%	1.2%	0.2%
Aroostook	98.8%	0.4%	0.5%	0.4%
Cumberland	96.6%	1.9%	1.0%	0.4%
Franklin	96.8%	0.7%	1.2%	1.2%
Hancock	96.1%	1.5%	1.5%	0.9%
Kennebec	97.2%	1.7%	0.8%	0.3%
Knox	97.3%	1.0%	1.1%	--
Lincoln	97.3%	1.4%	1.1%	--
Oxford	97.0%	1.3%	1.5%	--
Penobscot	98.0%	1.0%	0.7%	0.2%
Piscataquis	97.9%	--	0.9%	--
Sagadahoc	97.5%	1.5%	0.8%	--
Somerset	97.4%	0.8%	1.4%	0.4%
Waldo	96.7%	2.4%	0.6%	--
Washington	97.7%	0.8%	0.6%	0.9%
York	96.6%	1.5%	1.5%	0.4%

Behavioral Risk Factor Surveillance System 2007-2009

In Maine, data on the lesbian, gay, bisexual and transgendered populations has been very limited. 2010 US Census data captured same sex couples living together, but not other lesbians, gays, or bisexuals. Since 2004, a question on sexual orientation has been asked on Maine’s Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS data demonstrates that there are LGB populations throughout the state of Maine in every county. LGB data is also collected on the Maine Integrated Youth Health Survey for high school students, who more frequently report lesbian, gay or bisexual orientation. No on-going surveys or other health related data sources collect data on transgendered people in Maine.

### Disability

The term “disabled” covers a continuum of conditions that may include physical, cognitive, developmental and/or mental impairment. In 2001 the World Health Organization simplified the definition of disability by framing the continuum into two linking concepts of limitations in personal functioning ( basic activities such as mobility) and limitations in community life, (more complex

activities and interactions.)<sup>14</sup> In 2012, the BRFSS survey used this frame and began asking two questions: (a) need for special equipment (cane, wheelchair, special bed, or special telephone) and (b) activity limitations as a result of physical, mental or emotional problems.<sup>15</sup>

**Disability Status of Maine People**

	With	Without
<b>Total</b>		
Population	15.5%	84.5%
<b>Education</b>		
Less than High School	20.8%	6.1%
High School Graduate	38.9%	31.9%
Some College/Associate Degree	26.2%	30.0%
Bachelor’s Degree or Higher	14.1%	32.0%
<b>Employment (Non-institutionalized population)</b>		
Unemployment Rate	21.4%	26.4%
Not in Work Force	73.7%	67.9%
<b>Poverty</b>		
Below 100% FPL	23.0%	10.9%

[factfinder2.census.gov](http://factfinder2.census.gov) 2010

When the disability causes someone to be unable to take part in activities that contribute to one’s personal growth, fulfillment and community inclusion, health outcomes are adversely affected. It has been shown that those with disabilities have experienced difficulty with attaining the health care they need, have less access or use less preventative services, receive less social and emotional support, and have a higher unemployment rate.<sup>16</sup>

In Maine, over 200,000 people have a disability and are not institutionalized.<sup>17</sup> They are three times more likely to not finish high school than someone without a disability and twice as likely to be in poverty and have a notable higher unemployment rate. As discussed earlier, income and education are two key factors in determining health status.

**Geography**

Where you live can affect your health. Research studies have shown that:

- Rural Americans are more likely to have chronic illnesses, such as high blood pressure, heart disease, and diabetes.
- While gun fatalities from homicide are higher in urban areas, suicides caused by gun fatalities are disproportionately higher in rural areas.
- Many rural Americans lack access to treatment because appropriate transportation is either unavailable, too costly or healthcare facilities are too far from home.<sup>18</sup>

The Centers for Disease Control and Prevention, National Center for Health Statistics has developed an Urban-Rural Classification Scheme for counties. The scheme is built upon the Office of Management and Budget delineation of metropolitan and nonmetropolitan counties and uses the cut point of the US Department of Agriculture Rural-Urban continuum codes. The six developed categories are:

- Metropolitan Counties
  - *Large central metro*: Counties in Metropolitan Statistical Area (MSA) with 1,000,000 or more population that contain at least 250,000 in the principal city (none in Maine)
  - *Large fringe metro*: Counties in MSA over 1,000,000 that do not meet the large central classification (none in Maine)
  - *Medium metro*: Counties in MSA of 250,000-999,999 (Cumberland, Sagadahoc and York)
  - *Small metro*: Counties in MSA of 50,000-249,999 (Androscoggin and Penobscot)
- Nonmetropolitan Counties
  - *Micropolitan*: Counties in micropolitan statistical area (Kennebec and Knox)
  - *Noncore*: Counties not in a micropolitan statistical area (all other Maine counties)

### Urban-Rural Classification

	Urban-Rural Classification	Population	Poverty
Androscoggin	Small Metro	107,702	14.2%
Aroostook	Noncore	71,870	15.7%
Cumberland	Medium Metro	281,674	10.7%
Franklin	Noncore	30,768	16.8%
Hancock	Noncore	54,418	12.4%
Kennebec	Micropolitan	122,151	12.2%
Knox	Micropolitan	39,736	11.4%
Lincoln	Noncore	34,457	9.8%
Oxford	Noncore	57,833	13.4%
Penobscot	Small Metro	153,923	16.3%
Piscataquis	Noncore	17,535	16.9%
Sagadahoc	Medium Metro	35,293	9.4%
Somerset	Noncore	52,228	18.5%
Waldo	Noncore	38,786	14.5%
Washington	Noncore	32,856	20.4%
York	Medium Metro	197,131	8.7%

Behavioral Risk Factor Surveillance System 2007-2009

In the United States, 65.3% of all counties are in Nonmetropolitan or Rural counties, yet only 16.7% of the nation’s residents reside in them. In Maine, 11 of the 16 counties (or 68.8%) are in nonmetropolitan counties with 41.6% of residents living in these areas. For Metropolitan counties in Maine, the average poverty rate is 11.7% versus 14.2% for Nonmetropolitan areas. Further, for Noncore counties in Maine, the poverty rate is 15.2%.<sup>19</sup> This demonstrates that, in Maine, the more rural the area, the higher the rate of poverty. Living in a rural area means negotiating challenges to access to personal health and social services, and prevention services for the whole community. While rural communities are rich in assets of people and local community, living in more-rural to most-rural areas is a determinant of health by itself.

### Gender

Merriam-Webster dictionary defines gender as the behavioral, cultural, or physiology traits associated with one sex (male or female). While the term sex is a biological distinction, gender refers to socially constructed roles. Health disparities between men

and women occur when differences between men and women systematically favor one group over the other. For example, research has shown that:

- Women may live longer than men, but they also tend to suffer more disease and disability during their lifetime.
- Depression is twice as common among women compared to men, and is predicted to be a leading cause of disability by 2020.
- Victims of intimate partner violence are five times more likely to be women than men.
- Men of all race/ethnicities are two to three times more likely to die in motor vehicle crashes than are women, and death rates are twice as high among American Indians/Alaska Natives.
- Men of all ages and race/ethnicities are approximately four times more likely to die by suicide than females.<sup>20</sup>

### Gender Comparison

	Male	Female
<b>Poverty</b>		
Below 100% FPL	6.3%	7.9%
<b>Education</b>		
Less than High School	12.5%	10.5%
High School Graduate	34.0%	28.1%
Some College/Associate Degree	43.5%	49.5%
Bachelor’s Degree or Higher	10.1%	11.8%
<b>Poverty, by education</b>		
Less than High School	25.5%	26.4%
High School Graduate	12.1%	16.3%
Some College/Associate Degree	8.3%	11.3%
Bachelor’s Degree or Higher	5.0%	5.0%

factfinder2.census.gov 2010

In Maine, the female population is older than most other states with a median age of 43.4 years. Maine women are more likely to be poor, in poverty despite educational status, and over the past 10 years, more racially diverse. In the Maine Women's Health Report 2011, findings demonstrated that:

- Maine women's earnings lag behind those of men, this trend becomes more pronounced as women age. In 2009, the median income for Maine males of all ages and occupations was \$42,156 and for Maine females it was \$32,314.
- Poverty is a challenge facing many Maine women, especially older women and women with children. Between 2005-2009, 12.2% of Maine women 65 years or older lived below the federal poverty level, compared to only 6.7% of men 65 years or older. In Maine, between 2005 and 2009, an estimated 8.6% of families lived in poverty. Among female-headed single parent families with children, 39.3% were living in poverty compared to 5.5% of married couples with children and 20.6% of families with male head of household with children.
- Education and income were inversely related to unhealthy physical and mental health days per month. Women who had not graduated from high school reported more than two times the number of mentally unhealthy days and three times the number of physically unhealthy days per month compared to women with a college degree.<sup>21</sup>

### Age

The leading causes of death differ at each phase of life, based on biologic as well as social needs and the environment in which people live. Some differences in health status and risks are developmental in nature, while others related to increased vulnerabilities such as being very young, or very old, when there is basic dependency on others for aspects of daily living (shelter, food, mobility, etc.). Social determinants of differing cultural and social

norms influence access to services and supports for functioning and health status for people in different age groups.

The 2010 US Census estimates Maine has a median age of 42.7 years, which is the highest in the United States. An aging population, a low birthrate, and a small minority population are all listed as contributing factors. Maine has a lower percentage of 0-18 year-olds and a high percentage of people 65 years and older. Both elders and parents of young children face barriers, such as lack of access to transportation, which make accessing health care services challenging for them.<sup>22</sup>

### References

1. CDC health disparities and inequalities report- United States (2011). Morbidity and Mortality Weekly Report [MMWR] Suppl, Vol. 60. Centers for Disease Control and Prevention/US DHHS. Retrieved from [cdc.gov/mmwr/pdf/other/su6001.pdf](http://cdc.gov/mmwr/pdf/other/su6001.pdf)
2. Community Health Status Indicators Report CSHI (2009). Community Health Status Indicators Project Retrieved from [cdc.gov/CommunityHealth/homepage](http://cdc.gov/CommunityHealth/homepage)
3. Waponahki Health Assessment (2012). Contact Office of Health Equity, Maine CDC, Lisa. Sockabasin@maine.gov for more information.
4. Ezzati, M. Friedman, AAB, Kulkarni, SC, Murray, CJL (2008). The reversal of fortunes: Trends in county mortality and cross-country mortality disparities in the United States. PLoS Med 5(4): e66. Doi: 10:1371/journal.pmed.0050066.
5. US Census (2010). Retrieved from [census.gov](http://census.gov)
6. National Stakeholder Strategy for Achieving Health Equity (2012). Partnership for Action to End Health Disparities. US Office of Minority Health/DHHS. Retrieved from [minorityhealth.hhs.gov/npa/templates/browse.aspx](http://minorityhealth.hhs.gov/npa/templates/browse.aspx)

7. Revisions to the standards for the classification of federal data on race and ethnicity (1997). Federal Register Notice., October 30, 1997. U.S. Office of Management and Budget. [OMB Statistical Policy Directive 15]. Retrieved from [whitehouse.gov/omb/fedreg\\_1997standards/](http://whitehouse.gov/omb/fedreg_1997standards/)
8. National Healthcare Disparities Report (2011). Chapter 10. Agency for Healthcare Research and Quality. Retrieved from [ahrq.gov/qual/nhdr11/chap10a.htm](http://ahrq.gov/qual/nhdr11/chap10a.htm)
9. US Census (2010). Retrieved from [census.gov](http://census.gov).
10. National Healthcare Disparities Report (2011). Chapter 10. Agency for Healthcare Research and Quality. Retrieved from [ahrq.gov/qual/nhdr11/chap10a.htm](http://ahrq.gov/qual/nhdr11/chap10a.htm)
11. Freudenberg N, Ruglis J. Reframing school dropout as a public health issue. (2007). Preventing Chronic Disease: Public Health Research, Practice and Policy. US Center for Disease Control and Prevention/DHHS. 2007;4(4). Retrieved from [cdc.gov/pcd/issues/2007/oct/07\\_0063.htm](http://cdc.gov/pcd/issues/2007/oct/07_0063.htm).
12. The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding (2011). Board on the Health of Select Populations; Institute of Medicine. National Academic of Sciences. Retrieved from [iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx](http://iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx)
13. Gays, Lesbians and Bisexuals in Maine: a Behavioral Health Profile (2011). Maine Center for Disease Control and Prevention. Retrieved from [maine.gov/dhhs/mecdc/navtabs/data.shtml#programarea](http://maine.gov/dhhs/mecdc/navtabs/data.shtml#programarea)
14. International classification of functioning, disability and health (ICF) (2001). Geneva, Switzerland: World Health Organization. Retrieved from [who.int/classifications/icf/en](http://who.int/classifications/icf/en).
15. Healthy People 2020. Retrieved from [healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=9](http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=9)
16. Get The Facts - Health Disparities: The Basics. (2013). Factsheet. American Public Health Association. Retrieved from: [apha.org/NR/rdonlyres/54C4CC4D-E86D-479A-BABB-5D42B3FDC8BD/0/HlthDisparty\\_Primer\\_FINAL.pdf](http://apha.org/NR/rdonlyres/54C4CC4D-E86D-479A-BABB-5D42B3FDC8BD/0/HlthDisparty_Primer_FINAL.pdf)
17. Urban-Rural Classification Scheme, Vital and Health Statistics, Series 2, Number 154, January 2012. National Center for Health Statistics, US Centers for Disease Control and Prevention/DHHS. Retrieved from [www.cdc.gov/nchs/data\\_access/urban\\_rural.htm](http://www.cdc.gov/nchs/data_access/urban_rural.htm)
18. Mary Mederios Kent. What Explains the Disparities Between Men and Women's Health?. The Population Reference Bureau, Washington, D.C 2008. Retrieved from [prb.org/Articles/2008/dcpfactsheetgender.aspx](http://prb.org/Articles/2008/dcpfactsheetgender.aspx)
19. Get The Facts - Health Disparities: The Basics. (2013). Factsheet. American Public Health Association. Retrieved from: [apha.org/NR/rdonlyres/54C4CC4D-E86D-479A-BABB-5D42B3FDC8BD/0/HlthDisparty\\_Primer\\_FINAL.pdf](http://apha.org/NR/rdonlyres/54C4CC4D-E86D-479A-BABB-5D42B3FDC8BD/0/HlthDisparty_Primer_FINAL.pdf)
20. Maine Women's Health Report (2011). Maine Center for Disease Control and Prevention/DHHS and University of Southern Maine/Dept. of Applied Medical Science. Retrieved from [maine.gov/dhhs/mecdc/health-equity/womens-health/documents/2011-report-introduction.pdf](http://maine.gov/dhhs/mecdc/health-equity/womens-health/documents/2011-report-introduction.pdf)
21. Maine Women's Health Report (2011). Maine Center for Disease Control and Prevention/DHHS and University of Southern Maine/Dept. of Applied Medical Science. Retrieved from [maine.gov/dhhs/mecdc/health-equity/womens-health/documents/2011-report-introduction.pdf](http://maine.gov/dhhs/mecdc/health-equity/womens-health/documents/2011-report-introduction.pdf)
22. Census 2010. Retrieved from [www.census.gov](http://www.census.gov)